AHCCCS is Arizona's Medical Assistance Program (Medicaid)

Renewal Verification from the Tribal/Regional Behavioral Health Authority

Customer:	AHCCCS ID:	Customer #:
	Date:	
	Eligibility Specialist: Phone: Fax:	

To Behavioral Health Staff

Please complete this form to help the above named customer keep his/her AHCCCS eligibility.

When completed, please sign and return the form to the SSI-MAO Eligibility Specialist shown above for processing.

Any service provider familiar with the customer may complete this form using the RBHA's clinical information regarding the person.

Please fill in the name and identify the current functional limitation

The applicant's medical record indicates that the customer named above Mr/Ms/Mrs_____ continues to have a diagnosis that is one of the qualifying diagnoses for SMI determination.

The applicant has the following functional limitations:

☐ Inability to live in an independent or family setting without supervision (Self Care/Basic Needs):
The person's capacity to live independently or in a family setting, including the capacity to provide or arrange for needs such as food, clothing, shelter and medical care.
(For SSI-MAO Staff: A1)

☐ The person poses a risk of serious harm to self or others (Social/Legal and/or Feeling/Affect/Mood:
The extent and ease with which the person is able to maintain conduct within the limits prescribed by law, rules and social expectations, and/or the extent to which the person's emotional life is well modulated or out of control.
(For SSI-MAO Staff: A2)

☐ The person displays dysfunction in role performance:
Person's capacity to perform the present major role function within society- school, work, parenting or other developmentally appropriate responsibility.
(For SSI-MAO Staff: B1)

☐ The person is at risk for deterioration:
The individual does not currently meet any one of the above functional criteria but may be expected to deteriorate to such a level without treatment.
(For SSI-MAO Staff: B2)

Name of person completing the form: _____Title:_____Phone:_____
Signature of person completing the form: _____ Date: _____

Please Note: This form will be used for processing AHCCCS eligibility renewals. It does not replace, augment or supercede the official SMI Determination form.